RI Department of Health

License Application and instructions for

Organized Ambulatory Care Facility

RI General Laws Chapter 23-17-10

Licensee Name: The American Center for Bioregulatory Medicine and Dentistry

Licensee Number: _____

OCT 10 2018

Reason for application (Please check all that apply):

1. ☒ Initial Licensure
2. ☐ Change of address: What is your current license number:_____
3. ☐ Change of ownership: What is your current license number:_____
4. ☐ Licensee Name Change

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Mark "NA" for questions that are "Not Applicable". Incomplete forms will not be processed and your license will not be issued. Please use a ball point pen.
- The fee for this application is $650 for profit. Only one $650 fee is required for non-profit with multiple locations. Non-profit charitable community health centers are exempt from this fee.
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application, return it with the required fee and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this renewal application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the information below:

Medical Director Information: Please provide the name of the Medical Director for this facility. **NOTE: This section must be completed as a requirement of your license renewal.**	Name: Dr. Heather Tallman Ruhm License Number: MD16440
License Sub-Type: Please select one	☒ Profit ☐ Non-Profit
Compliance with Conditons of Approval Please check yes or no.	This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☒ Yes ☐ No

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Facility Name: Please provide the name of the agency (as known to the public) for which you are applying for licensure.	Name: The BioMed Center
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this agency.	Name: Dr. Heather Tallman Ruhm Phone Number: 888-824-6633
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. **(Not published on HEALTH website).**	Address Line 1: 111 Chestnut Street Address Line 2: Address Line 3: Address City, State, Zip Code: Providence, RI 02903 Address Country: USA Phone: 833-824-6633 Fax: Email Address:
Facility Location Information: Please provide the location information for this facility. **(Published on HEALTH website).**	Address Line 1: 111 Chestnut Street Address Line 2: Address Line 3: Address City, State, Zip Code: Providence, RI 02903 Address Country: USA Phone: 833-824-6633 Fax: Email Address: www.thebiomedcenterne.com NOT WEBSITE
Ownership Type: Please check ONE	☐ Corporation ☒ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: American Center for Bioregulatory Medicine and Dentistry, LLC DBA: The BioMed Center

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Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 111 Chestnut Street Address Line 2 Address Line 3 Address City, State, Zip Code Providence, RI 02903 Phone: 833-824-6633 Fax: Email Address: www.thebiomedcenterne.com
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type LLCs (multiple) Name of Organization Bioregulatory Medical, LLC, Bioregulatory Dental, LLC, and Robert Woodford Enterprises, LLC Address Line 1 c/o American Center for Bioregulatory Medicine and Denstistry, LLC Address Line 2 111 Chestnut Street Address Line 3 Address City, State, Zip Code Providence, RI 02903 Phone: 833-824-6633 Fax: Email Address: www.thebiomedcenterne.com Websites
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: 111 Realty Partners Address Line 1 111 Chestnut Street Address Line 2 Address Line 3 Address City, State, Zip Code Providence, RI 02903 Phone 401-831-1240
Community Health Center:	Community Health Center Is your facility designated as a non-profit charitable Community Health Center? Yes ☐ No ☒
Services Provided: (Please check which services are provided by your employees or through written agreement with others.	☒ General Medical Services ☐ Laboratory Services ☐ MRI Services ☐ Radiology Services ☒ Dental Services ☐ Other: List Additional Services

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Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number: [redacted]

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Michael Baldwin — 10.16.18

Signature of Authorized Person — **Date of Signature (MM/DD/YY)**

Michael Baldwin

Printed Name of Authorized Person

Manager, ACBMD, LLC

Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.

Attachment to OACF License Application for The American Center for Bioregulatory Medicine and Dentistry, LLC

List of All Direct and Indirect Owners

Name	Occupation	Address	Relationship	Ownership Interest
Robert Dulaney	Private Investor	3500 National City Tower, 101 South 5th Street, Louisville, KY 40202	Member, Robert Woodford Enterprises, LLC ("RWE, LLC")	100%
			Owner (through RWE, LLC) Bioregulatory Medical, LLC	65%
			Owner (through RWE, LLC) Bioregulatory Dental, LLC	65%
			Owner (through RWE, LLC) The American Center for Bioregulatory Medicine and Dentistry, LLC	65%
Dr. Jeoffrey Drobot	Naturopathic Doctor	10572 E. Meadowhill Drive, Scottsdale, AZ 85255	Member and Manager, Bioregulatory Medical, LLC	35%
			Owner (through Bioregulatory Medical, LLC) and Manager, The American Center for Bioregulatory Medicine and Dentistry, LLC	17.5%
Dr. Gerald Curatola	Dentist	521 Park Avenue, New York, NY 10065	Member and Manager, Bioregulatory Dental, LLC	35%
			Owner (through Bioregulatory Dental, LLC) and Manager, The American Center for Bioregulatory Medicine and Dental, LLC	17.5%

Ownership Structure for the American Center for Bioregulatory Medicine and Dentistry